

# Pediatric Medical Records Release Authorization

Please complete all sections of this authorization form to facilitate the release of the pediatric patient's medical records. This form is designed to be filled out and printed for signature.

Patient (Child) Information

Patient's Full Name:

Date of Birth (MM/DD/YYYY):

Address:

Parent or Legal Guardian Information

Guardian's Full Name:

Relationship to Patient (e.g., Mother, Father, Legal Guardian):

Contact Phone Number:

Authorize Release From (Disclosing Entity)

Facility or Clinic Name:

Pediatrician/Doctor Name:

Address:

Phone Number:

Fax Number:

Release Records To (Receiving Entity)

Facility, Clinic, or Individual Name:

Address:

Phone Number:

Fax Number:

Scope of Information to Release

Specify records to be released (e.g., "All immunization records", "Growth charts only", "Complete medical history"):

Specify date range of records to release (e.g., "All dates" or "From 2020 to 2023"):

Purpose of Disclosure

Specify reason for transfer (e.g., "Moving", "Changing physicians", "Referral to specialist"):

Authorization and Acknowledgements

By signing below, I authorize the release of the specified medical records for the pediatric patient named above. I understand that this authorization is voluntary and that I may revoke it in writing at any time.

Printed Name of Parent/Guardian:

Signature of Parent/Guardian (Sign after printing):

Date Signed (MM/DD/YYYY):